

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2026

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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2026 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

Mailing Address:

STREET ADDRESS	CITY	STATE	ZIP
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Physical Address:

STREET ADDRESS	CITY	AL	ZIP
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County of Location:

Facility Telephone:

(AREA CODE) & TELEPHONE NUMBER

Facility Fax:

(AREA CODE) & TELEPHONE NUMBER

This reporting period is for March 1, 2025, through February 28, 2026; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY

MONTH DAY

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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FOR OFFICE USE ONLY

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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I. OWNERSHIP

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify)

II. MANAGEMENT

Does this facility operate under a management contract? Yes No

Management Firm: _____
Name

Base Address	City	State	Zip
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III. FACILITIES

Total number of licensed beds: _____

IV. ADMISSIONS

Total admissions for the reporting period: _____

Admissions by source of payment:

Private Pay	_____
Other (specify) _____	_____

V. DISCHARGES

Total discharges (include deaths) _____

VI. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE FOR THE ENTIRE REPORTING PERIOD
(Total must agree with the totals provided in Sections IV, VI-B and VIII.)

a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other (specify) _____	
TOTAL	

B. TOTAL ADMISSIONS BY AGE AND GENDER FOR THE ENTIRE REPORTING PERIOD
(Total must agree with the totals provided in Sections IV, VI-A and VIII.)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

VII. RESIDENT DAYS

- 1. **Number of licensed beds**
(Section III of this report) **x 365**

- 2. Multiply line 1 by 365 for total available days =

- 3. **Total number of days beds were unoccupied** due to
vacancies, discharges and deaths (also include 365 days for
each bed that is licensed but not set up for use in this facility)

- 4. **TOTAL RESIDENT DAYS** (subtract line 3 from line 2)

*****Make and keep a copy of the completed report for the facility's records before submitting to SHPDA.**
Pursuant to ALA. ADMIN. CODE r. 410-1-3-.09, all Mandatory Reports shall be submitted electronically [via e-mail] to data.submit@shpda.alabama.gov.

